MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

DUTY STATUS FORM (SF 600-DSF)

Fit For Duty: (Yes/No)

Sick in Quarters until _____
Convalescent Leave until _____

Work/Class as Tolerated until _____
Desk Work Only until _____

Activity Recommendations (below) until_____

Duties	Yes	No	Physical Fitness Assessment	Yes	No
Flying Duties			Sit-ups		
Deployable			Push-ups		
Sea Duty			1.5 mile Run		
Boat Duty (Pier Side)			100 meter Swim		
Swimming			Flexibility		
Other _____			Other _____		
Aerobic Conditioning & Weight Training	**Yes**	**No**	**Aerobic Conditioning & Weight Training**	**Yes**	**No**
Unlimited Running			Run at own pace and distance		
Unlimited Walking			Walk at own pace and distance		
Unlimited Swimming			Swim at own pace and distance		
Unlimited Biking			Bike at own pace and distance		
Unlimited Weight Training			Weight Training at own pace and weight		

No Standing for greater than _____ min/hrs

No use of: _____

No Sitting for greater than _____min/hrs

No lifting or carrying more than _____ lbs

Additional Duty Status Information

Member must follow-up with Medical/Dental for **Duty Status** determination on _____.

Based on the member's condition(s), the member is expected to fully recover by _____.

This condition may require a **Temporary Limited Duty** (TLD): Yes / No **Medical Board:** Yes / No

Aviation Recommendations

☐ Temporary Medical Suspension
☐ Temporary Medical Suspension Following A/C Mishap
☐ Permanent Medical Disqualification
☐ Permanent Medical Disqualification following A/C Mishap

Simulator Allowed: Y / N
Ground Runup Allowed: Y / N

I certify that I have been notified of the recommendations above and that I MAY NOT perform aviation duties as of: _____.

Member's Signature:_____

Name & Rank of Medical Provider	Signature	Date

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*

REGISTER NUMBER	WARD NUMBER